MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, November 16, 2001
9:01 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
What next for Medicare+Choice
Scott Harrison

MR. HACKBARTH: Next up, what's next for Medicare+Choice?

DR. HARRISON: Today we have assorted topics on Medicare+Choice. The panel you see here will present four different topics related to Medicare+Choice that will give you a chance to see where we are on these Medicare+Choice issues. We don't have any draft recommendations to present today. Instead we will listen to your discussions then come back in December with Medicare+Choice draft recommendations.

Susanne will start with a quick look at the benefits that will be offered by Medicare+Choice plans for 2002. Next Dan will give you an update on the current status and next steps for risk adjusting payments to the plans. And Ariel Winter, in his MedPAC debut, will follow with a report on the GME carve-out from Medicare+Choice payment rates. Finally, I will take a look at the issue of using competitive bidding to set payment rates.

Susanne?

DR. SEAGRAVE: Good morning. At the October meeting, the Commission expressed some interest in getting information about the 2002 Medicare+Choice benefit packages. I am here today to present some preliminary findings of our analysis. I want to stress that these are very preliminary.

So far staff have analyzed the benefit package along two dimensions: the premiums that plans are charging and the outpatient prescription drug benefits that plans are offering. We have not yet looked at hospital coverage and inpatient coverage and those sorts of issues.

In the first slide we present national trends from 1999 to 2002 in beneficiaries' access to plans with selected benefits. I think it's fair to say in general that access to these types of benefits have declined from 1999 to 2002. I wanted to note here that we are looking at all Medicare+Choice plans except for the private fee-for-service plans. I'll allude to that more in a minute. As you can see, from 1999 to 2002 access to zero premium plans in particular declined a lot. It fell by about half, in fact.

You can see in this slide that beneficiaries who live in urban areas still have modest access to many of these types of benefits. However, in rural areas I think it's fair to say that access is close to none in rural areas. But I wanted to point out that in fact almost 30 percent of beneficiaries in urban areas have access to a zero premium plan that also offers a drug benefit.

As you can see, there's also a continuing disparity in

access between floor and non-floor counties. By floor counties I mean those counties in which the Medicare+Choice base payment rate is either $475 or $525. The non-floor counties include all other counties.

DR. NEWHOUSE: Susanne, can I ask, these are percentages of plans or percentages of beneficiaries?

DR. SEAGRAVE: These are percentages of beneficiaries.

DR. NEWHOUSE: So they're beneficiary weighted.

DR. SEAGRAVE: Yes. We see that access to zero premium in prescription drug benefits in floor counties still lag behind the access in non-floor counties. I wanted to point out here again that we have excluded the private fee-for-service plans because we typically do exclude them in this kind of analysis. But even if we included them, the private fee-for-service plans do not have zero premiums. In fact I think one of the plans has a $78 premium and the other one has an $89 premium, and neither plan offers prescription drug benefits.

In the previous three slides I've given you sort of a 30,000-foot overview looking at whether a plan offers a prescription drug benefit or not, and other whether it offers a zero premium or not. We haven't gotten very far in looking more in depth at these benefits, but I wanted to just give you a flavor, more sort of a qualitative flavor of what we have observed might be going on underneath the surface.

The first trend that we find is, obviously, that premiums are increasing. In fact if we look at all plans we find that the average premium in 2001 was about $23, and in 2002 will be about $35. If we limit our analysis to only those plans that charged a positive premium the average increases from $41 in 2001 to $58 in 2002. So that gives you a flavor of how much premiums are increasing.

Among plans that offer a prescription drug benefit, we examined them to see how that benefit might have been changing next year. Two general patterns that I just wanted to point out are emerging. First is that plans are increasing their copayments for outpatient prescription drugs, which I don't think is a big surprise to anyone. And the second trend that I particularly found interesting is that many of the plans are dropping their brand name drug coverage. They're continuing to offer generic drug coverage but are dropping the brand name coverage.

So those are some of our preliminary findings, and if the Commissions like we will continue to come back with more findings.

MS. ROSENBLATT: Susanne, this is a great direction. I just have a suggestion. We heard from Paul Ginsburg yesterday morning on overall trends affecting under-65 non-Medicare population. I

think it might be interesting to look at the trends that we're seeing in Medicare+Choice alongside of what trends are we seeing in the overall industry.

I think one analysis that I might be interested in, when you're talking about going from, I think you said $41 to $58, that's almost like what's happening to the employee portion of a total commercial premium rate. You're only see a piece of the total. So even though the percentage sounds very high, if you were to say, what's the total cost of the program if you added in the Medicare payment as well as that premium and then said, what's that percentage, and how does that percentage compare to the way we're seeing commercial premiums go up, I think you'd have a more apples to apples comparison.

DR. ROWE: Susanne, I think it would be helpful also if you can get these data, and I don't know whether you can, to look at the proportion of the plans that are at the maximum-permitted premium, because unlike the situation in the commercial HMO or a plan where there is no statutory limit to what it could go up to.

As I said at a prior meeting, I think that a lot of the plans that stayed in Medicare+Choice did so by maxing out on the permitted premium in their area, and they're kind of on the cliff of dropping out of the program because they've got nowhere else to go with respect to increasing revenues. It would be interesting to know what proportion of the plans are at the maximum compared to what proportion were at the maximum before.

In addition, one of the factors that that would provide insight in is, while there has been this increase from $41 to $58, part of that population could not increase; they were already at the maximum, so they didn't increase. So that the proportion of the plans that increased, as opposed to the ones that could increase is -- the denominator should be the ones that were not at the maximum -- would also be an interesting number. So those would be, if you have those data, two suggestions.

DR. HARRISON: Jack, the data there is a little strange because it's not that there's a maximum premium. There's a maximum of copays plus premium. I'm not quite sure how we would find that, because if you were going to do an ACR proposal my guess is you would max that out and then charge a premium above that for supplemental benefits. I'm not quite sure how you'd tease that out otherwise.

DR. ROWE: The plans have the data.

DR. HARRISON: But they still make choices along the premium-copay continuum, and I'm not quite sure how that would --

MS. NEWPORT: Jack, I think he's right. It would be difficult. It's not that you exhaust your premium and then go to the other copays. You build it differently so that the max on your premium is something that, depending on your market, you may

never theoretically go to it.

DR. ROWE: I understand, but I guess I was looking for those that felt they don't have any room.

DR. HARRISON: Now there is an issue there and it's a geographic issue, in that plans in New York, for instance, may -- the out-of-pocket maximum for beneficiaries is calculated on a national average and that does not vary by area. So plans in New York may have a disadvantage because if their patients have higher copays they're not going to be able to -- they may hit their cap faster. So that may be something we would want to look at.

MR. FEEZOR: These figures are fairly close to what we've observed within CalPERS in terms of our Medicare supplemental market. Susanne and the rest of the team, I don't know whether there's any -- I'm curious as to the non-availability of Medicare+Choice plans in urban counties where in fact there is a good HMO market, or there might be an HMO market.

In California we're looking -- there is very clearly an urban-rural issue, but there's also what I call the non-competitive health care markets where in fact choices are not available. It's an issue that I think that -- maybe it's unique to California, but when I think of Monterey County it's hard to think of that as a rural county, and yet that's one of the -- for instance, an area that we don't have choice. So I don't know whether you can find any anecdotal or information relative to why choices are not in some of the urban areas would be interesting.

MS. ROSENBLATT: I just want to pick up on what Jack said. I think there is an area of investigation there. I'm not an expert on it, but there is somebody at Wellpoint I could put you in touch with. There's an actuary that really understands how the actuarial value of the out-of-pocket benefits goes into this. I think there is an interplay there that's worth considering.

MR. HACKBARTH: Okay, we should go ahead and move ahead to the next step. Who's up now?

DR. ZABINSKI: Today I'm going to talk about the status of risk adjustment in Medicare+Choice. Risk adjustment in the Medicare+Choice program has received considerable attention since the program was created, and today I'll discuss the status of that development. But before doing that I think it would be useful to review why risk adjustment itself is important.

Now the purpose of risk adjustment is to pay plans fairly for the expected cost of their enrollees if base payment rates are set properly. It's important to understand that fair payments can only occur if both the base rates and risk adjustment work properly. If both are accomplished, plans will not lose or gain based on whether they attract beneficiaries in good health or bad health. Instead they would compete on the

basis of benefits and services. Moreover, accurate payments for enrollees with serious conditions will give plans greater incentives to develop effective care management programs for them.

Effective risk adjustment also would allow CMS to avoid overpayments or underpayments in the aggregate. Under the demographic system that is currently in use, for example, plans are overpaid for healthy enrollees and underpaid for those in poor health. Consequently, the Medicare+Choice program would be underpaid or overpaid in the aggregate if health status for enrollees differs from the overall average.

Finally, effective risk adjustment is necessary to attain the Commission's recommendation from March 2001 of financial neutrality between Medicare+Choice and traditional Medicare. The intent of that recommendation was to make payments between the two sectors equal after accounting for risk differentials.

Now on to the idea of the status of risk adjustment. We're currently a long way from an effective risk adjustment system. Currently there's a blend of a demographic system that was in use before the Medicare+Choice program was established that's blended with a system that uses the demographic data and diagnoses from hospital inpatient stays. It's the PIP DCG model. Neither of these models performs exceptionally.

Now CMS had intended to replace the blended system in 2004 with a multiple site system that uses demographics and all diagnoses from inpatient and outpatient and physician office encounters. But plans complained about the burden of collecting this full encounter data so the Secretary suspended the collection of the outpatient and physician data in May 2001.

Currently CMS is looking for an alternative that would not require plans to submit the full encounter data. But if the agency fails to develop an alternative, my understanding is that collection of the full encounter data will recommence in July 2002.

In any event, we believe that whatever the model that CMS ultimately develops should reflect a number of principles. Two of these principles are simply restatements of previous recommendations that the Commission has made. First is that risk adjustment should use diagnoses from multiple sites of care as quickly as feasible.

Second, payments in Medicare+Choice and traditional Medicare should be equal after accounting for risk. The second recommendation is important because it indicates that risk adjustment should redistribute resources between Medicare+Choice and traditional Medicare.

For example, if Medicare+Choice enrollees are healthier on average than fee-for-service beneficiaries, payments per

beneficiary should be lower in Medicare+Choice to the extent of the difference in the health status. Conversely, if Medicare+Choice enrollees are less healthy on average than fee-for-service beneficiaries, payments per enrollee should be higher in Medicare+Choice than traditional Medicare.

Now we've also identified three other principles that are not based on recommendations. First, simply that risk adjustment should be based on data that can be quantified and that both CMS and the plans can collect.

Second, we recognize that data collection is costly to plans, therefore the data collection should be pursued with respect to a principle that the cost of collecting the data should not be disproportionately higher than the benefits from paying more accurately.

Finally, risk adjustment should not have the potential to distort clinical decisionmaking. For example, looking at the PIP DCG model that's currently in use, payments for enrollees with inpatient stays in the previous year are increased, but that model does not increase payments for enrollees if the only diagnoses is from outpatient system encounters. Some have argued that this gives plans incentives to hospitalize enrollees in situations where they might otherwise treat in outpatient settings. But I'd like to point out that CMS has implemented measures that make this issue somewhat irrelevant in practice.

Now this slide, we have two risk adjustment systems that are under consideration. Both are intended to reduce the burden of data collection on plans. Under option one, plans would submit primarily diagnoses from inpatient stays, but they would also submit a few diagnoses from outpatient encounters, but far fewer than what CMS would have had them submit under full encounter data. The plans would obtain the outpatient diagnoses from several sources, including claims-like encounter data, disease registries, lab data, and drug data. These data would then be applied to a multiple site model that CMS had considered before data collection was suspended.

A second option would have plans submit full encounter data with the same amount of diagnoses they would have submitted if data collection was not suspended. However, the plans would submit far fewer variables. CMS had been asking plans to submit quite a few variables, but diagnoses, date of service, and enrollee ID are actually the only variables necessary to run a multiple site model.

Now when we compare these two options we found three interesting differences. First, option one may not yield financial neutrality with fee-for-service Medicare. This is because CMS would use fee-for-service claims to identify beneficiaries' diagnoses and estimate the costliness associated

with each condition.

In option two, plans would identify their enrollees' diagnoses in an analogous way by using claims-like encounter data. But in option one, plans would use encounter data as well as data from several additional sources, such as drug data and disease registries.

Consequently, under option one plans would identify enrollees with conditions who could not be identified with claims data, so Medicare would pay more to Medicare+Choice for those enrollees than it would if those enrollees had stayed in traditional Medicare.

Second, option one would disadvantage plans that do not have access to disease registries or drug data because they would be able to identify fewer enrollees with conditions that result in higher payment. This would not be a problem in option two because all plans would have the ability to submit encounter data.

Finally, option two has greater power for predicting enrollees' cost because it would use more diagnosis information to classify beneficiaries than would option one. And because option two can predict costs more accurately, payments would more accurately reflect enrollees' costs.

I'd just like to close by saying that today our intention was simply to bring commissioners up to date on the status of risk adjustment. No action on their part is necessary, but of course we welcome their thoughts and their comments on the topic.

MS. ROSENBLATT: My thought, first of all, is I'm really tired of risk adjustment. We've been dealing with risk adjustment since 1993 I think, and it's really sad that we don't seem much further along today than we did back then.

I would like another option to be considered, if it's possible. One thing in the narrative struck me. I think you had a little table there that said, 6 percent of the claims exceed $25,000. First of all, let me say that the Blue Cross-Blue Shield Association would attempt to make data available for you to do risk adjustment studies, so you should -- and I think Scott knows who to contact. So I think it would be worthwhile to try to get some actual plan data and do some studies.

I think in doing those studies I think you should not only document the results but document data problems, because I think you're going to find lots of data problems. And actually having you experience those data problems and report on them would be helpful.

But I'd like to see some option explored that just looks at the tail to see what's going on. Because the experimentation that we've done at Wellpoint with risk adjustment, in order to get some of these methods, even methods that use ambulatory data,

to give good regression coefficients we've had to chop off the tail. I just don't think any of these really work very well, so why not do something that's very easy and that just focuses on the 10 percent of the claims that drive a lot of the dollars.

I also think it would be interesting to document, if you get data from different plans, are there plans that are showing that they have a better result than the average, or are there plans that are showing they have a worse result, what's the distribution? So I think just documenting where those all fall out --

DR. ZABINSKI: One question. I just want to make sure I understand when you say, better results, worse results. Are you saying --

MS. ROSENBLATT: Better than average health status versus worse than average health status.

DR. ZABINSKI: That's what I thought. Just wanted to confirm.

MR. HACKBARTH: Alice, when you say just focus on the tail, could you just explain a little bit more about how such a system --

MS. ROSENBLATT: I'm talking about something that would work like a reinsurance scheme where there would be a charge PMPM made to all the plans or something like that, to fund a pool that would then be used to pay plans based on -- for plans that were capitated, capitated providers you'd need to develop a fee-for-service equivalent. But payment for large amount claims.

MR. HACKBARTH: And you'd charge a premium to the plans based on the Medicare experience and how prevalent those costs are in Medicare. If they have a healthy population they would never pay for the insurance and --

MS. ROSENBLATT: Right. The idea of it is that you're only submitting data on those few claims, as opposed to data on all enrollees.

DR. ROWE: I have two points. One minor point, Dan, is that on the top of page 3 of your document you have an interesting thing. It starts on page 2. You say, finally a risk adjustment system should not have the potential to distort clinical decisionmaking. The PIP DCG model, for example, pays more for enrollees who have had an inpatient stay. This provides an incentive for plans to hospitalize enrollees in situations they might otherwise treat in the outpatient setting.

First of all, I think it's physicians generally who hospitalize patients, not plans, and I think that that's an important difference there. Secondly, unless you have some data to indicate that plans are hospitalizing beneficiaries unnecessarily, this is a relatively inflammatory statement and I don't think it adds anything to the general discussion. If you

have evidence, you might put it in. If you don't have evidence you might drop this out or say, although there's no evidence to indicate this, there is a theoretical -- or something. But I would prefer if we had doctors hospitalizing people, not plans.

DR. ROSS: Jack, we'd all prefer that. We were actually restating a concern expressed by this very commission in previous reports. It refers to an incentive, not to an actuality, since only 10 percent of the payment depends on that system.

DR. ROWE: I know. It's just people will take that sentence out independent of the footnote and the other sentences I think. I'm just concerned.

But secondly, I think there's an almost Alice-in-Wonderland nature to this from one point of view. I'm not sure any of these statements are wrong, but I believe the Medicare+Choice program is not growing. In fact I believe it's shrinking. I believe there is a concern in some quarters, including Congress, that it may not be adequately funded, and that some plans are dropping out based on that, or that's what they say the reason. I believe there is in fact some proposed legislation to change the funding. I believe that the beneficiaries in Medicare+Choice plans are generally felt still, although the gap is narrowing, to have a lower risk profile than in traditional Medicare.

Statements in here indicating that, of course we should pay based on the risk will in fact reduce the payments to the Medicare+Choice plans and increase the payments to traditional Medicare. For MedPAC to therefore, basically make the recommendation, which is in the body of what you've said and written that the M+C program should have reduced funding at a point in time when the rest of this is going on does make us seem a little out of touch, or out of the loop. I think that it might be helpful --

DR. REISCHAUER: You voted for it last year.

DR. ROWE: I understand. I'm just trying to put this in some -- make us relevant. We might have a statement saying that there is currently discussion about the proper level of funding in the Medicare+Choice program, or Congress is considering this, or the Secretary or CMS or somebody, and that in a properly funded M+C program in balance with Medicare there should be allocation according to the risk, or something like that. But just to have it here, irrespective of anything that's going on in the environment, it just seems a little out of touch.

MR. HACKBARTH: What we're trying to do is define what a properly funded program is, and our definition of that is that it ought to be equal to traditional Medicare after risk adjustment, and then the cards fall where they may. So yes, there is a disconnect between what plans have said about their funding and what we've recommended. Apparently we just don't see eye to eye

on a matter of principle.

DR. NEWHOUSE: Two comments. First on option one. By the time you got to the last page, Dan, option one seemed to have incorporated drug data, which I don't think is inherent in option one. But in any event, I am concerned about trying to use drug data in risk adjusting for several reasons. One is we don't have those data from traditional Medicare, and therefore, I don't know how we incorporate it into the weighing structure.

Second, I'm concerned about possibilities for gaming with paying substantially, potentially a few thousand dollars more on the basis of some number of scripts.

My second comment goes to Alice's remarks about dealing with the tail, which I have never been a fan of. One for theoretical reasons, and one for empirical data, which I'm happy to share with people. The theoretical reason is it doesn't do anything about the incentives on the other end to try to cream the good risk.

The empirical data are from some work by John Chapman who studied 50,000 people in an IPA, and he looked at the group that was in the top 5 percent of spenders in year one, and the top 30 percent -- the top 5 percent being some approximation to the tail. Then he looked at what happened to them downstream and how much a plan would have earned if it had been able to get rid of some fraction of people in the top 5 percent, some people in the top 30 percent.

What he found was there wasn't all that much profit in getting rid of the top 5 percent. The profit was really in getting rid of the top 30 percent. The reason for that seemed to be that the top 5 percent had a lot of one-time only high costs. They regressed to the mean faster than the top 30 percent, or the next level down where there was more chronic disease.

MR. FEEZOR: Joe, just a quick follow-up to your comment. Not having drug availability for the regular Medicare population, but certainly our examining the various risk adjustment indicators, the drug became a very powerful one in terms of within our population, so I wouldn't want to dismiss that altogether.

Just one other. Dan, following up on Alice's comments, we struggled with the data availability in a study that we did, just concluded last year in California. Given the fact that we have a significant number of different payment mechanisms, so we were very concerned about the availability of data and the quality of that data. I don't know whether you've seen that or not, but we'll make that available to you. It will probably be very helpful, because --

And then the final observation is, it may be helpful in looking at the concerns that various Medicare+Choice vendors have

had about the data availability for risk adjustment, and it may be helpful as we examine those concerns to take into account those who are either current players still in that market, or would like to be, versus those who in fact have made a corporate decision to in fact not be a part of that program any more.

MS. NEWPORT: For the new commissioners that haven't been punished with my diatribes on risk adjustment in prior years, theory is one thing. I think practical application and operational impact is quite another when you're trying to create a process where you can incentivize in a rationale way providers to participate in the program, and therefore provide a broader spectrum of benefits including drugs. This is where it really has fallen apart.

The whole genesis of suspending data collection in the outpatient sector was the overwhelming burden it was placing on providers and the plans to make sure and verify that they had the accurate data. And then not have those costs overwhelm the increased payment or the decreased payment in markets where your overall medical cost ratios couldn't be paid for by the revenue that was coming in from Medicare.

I think that's part of the problem. Yes, it sounds wonderful to risk adjust, and it sounds wonderful to say that this is a right-size of payment. But it is not necessarily theoretically sustainable in a marketplace.

The concern I've always had with this is that in saying the average payment is too high or too low never seems to recognize the added value that is required for plans to bring to the table, which includes drugs, which has been of immense value across the board in improving quality, in improving the type of care, the continuity of care, and incenting them to, pre-risk adjustment, move to quality care management programs across the board, and incentivizing some products in addition to what we offer in terms of continuity of care, and diabetes programs, and management of folks with chronic heart disease.

So I think that part of the issue, and hopefully enveloping some of the things that have been said, is that I feel like we're kind of trying to continue to support a process that isn't working, has had a negative impact on plan entry, and contributed to plan exits to the program. I think that in some of the citations you have in the paper the plans have, in an attempt to create an outpatient data process for getting to risk adjustment, have said we should seek data from other sources including pharmaceutical data sources, not any one of which is supposed to be totally effective.

But at least it is available and does give you an opportunity to get to the tail, as Alice says, and say, okay, here is a less perfect method for saying that the pricing of this

or the payment for this is a little more accurate without then overburdening the system in terms of what we have to do to go forward with it.

And more important than anything else is the predictability of payment over time and saying to your provider partners, we can guarantee you a certain level of payment for the costs you've incurred that is predictable and right-size. Because this never has really recognized that this is a system of integrated providers and vendors and hospitals and sites of care that are variable in and or themselves. So we're paid and then we have to drive that payment accurately down to those folks that we contract with, and they deserve predictability. That's where this all comes together in a rather awkward situation.

So I think that whatever the final paper is needs to reflect some of the market realities and concerns, and some of the efforts, good faith efforts that Alice has suggested as well, to come up with this process of better informed and leads to some better payment, but also makes sure the program continues. So this is not an easy area. It's not going to be an easy area. But I think we need to accommodate some of the realities of what is happening in the marketplace right now.

MR. HACKBARTH: Ariel, welcome.

MR. WINTER: Good morning. I will be discussing with you today the carve-outs of medical education payments for Medicare+Choice rates. First I will explain how plans are paid, and discuss the impact of the carve-out on plans and teaching hospitals. Then I will discuss a potential issue the Commission may wish to consider, which is how to treat medical education payments under the principle of financial neutrality between Medicare+Choice and fee-for-service.

The 1997 Balanced Budget Act set up a very convoluted payment system for Medicare+Choice plans. The plans payment rate is based on the county in which an enrollee lives. The county rate is the highest of a floor rate, a 2 percent increase from the prior year's rate, also called the minimum update, and a blend of national and local rates which is subject to a budget neutrality test that is intended to keep spending under the BBA's system in line with spending under the previous system.

The local rate is based on local fee-for-service spending minus medical education payments made to teaching hospitals, which is called the carve-out. This carve-out includes both direct graduate medical education payments and indirect medical education payments and is phased in over a five-year period. GME and IME are paid directly to teaching hospitals that serve Medicare+Choice enrollees. The national rate is simply the average of the local rates.

This slide has a table that shows the impact of the carve-

outs on M+C payment rates by type of county in 2000. Across the top row of the table, the counties are divided by type of M+C payment they received into blend counties, 2 percent updates, and floors. Down the left side, the counties are divided by the level of GME payment.

You'll notice first that the 2 percent update counties in the center are not affected by the carve-out, which is somewhat surprising. This is because under the payment system set up by the BBA, the base that's used to calculate the 2 percent updates was not subject to the carve-out. And the carve-out was also not taken from the floor rates. It was only taken from the base used to calculate the blended rates, which is why they're the only ones that are affected by the carve-out.

You can see that blend counties with above average GME payments experienced average reductions in payments of 3.5 percent, and blend counties with below average GME payments experienced average payment reductions of 2.5 percent in a year.

DR. REISCHAUER: This is only a fraction of what it would be in 100 percent.

MR. WINTER: Right, in 2000 it was 60 percent, in '01 it's 80 percent, and 2002 fully phased in at 100 percent.

DR. ROWE: It will be 5 percent.

MR. WINTER: One hundred in 2002. I think it will be actually 4 percent when it's fully phased in, 4 percent of total payments.

DR. ROSS: What Jack is getting at is if it's 3.5 percent in 2000 when that was at 60 percent, and when it goes to 100 that number would have been five.

MR. WINTER: That's right, exactly.

DR. ROWE: It would be like 3.5 and 5.5.

MR. WINTER: Here we have some examples of counties that were affected by the carve-out in 2000. The first set of counties are those with the largest reductions in total payments. Each county in that group experienced payment reductions of about $30 million in that year.

DR. ROWE: You mean plans in those counties. The counties didn't experience reductions.

MR. WINTER: Yes, plans in those counties. Thank you. The number after each county is the percent reduction in payments for plans in that county. Although the percent reductions are not very large, because each of these counties has many enrollees, the total payment reduction is significant.

The next set of counties are those with the largest percent reductions in payments. The first three counties listed, Pitt County, North Carolina, and Dodge and Olmsted Counties, Minnesota actually did not have plans, but I've decided to present them here to illustrate the highest -- the upper end of the range of

reductions.

The last two counties listed, Monroe, New York and New Haven, Connecticut were the counties with the largest rate reductions that actually had M+C plans in 2000.

Now I'll talk a bit about the impact of the carve-out on teaching hospitals. In 2000, total medical education payments made to teaching hospitals for serving M+C enrollees were about equal to the money carved out of the M+C payments. Even though the entire system is roughly budget neutral, the counties with hospitals that received medical education payments for M+C enrollees were not always the same counties with plans that lost plan payments due to the carve-out.

Counties that gained medical education payments under the carve-out system were those with high use of teaching hospitals by M+C enrollees. Counties with plans that lost payments under the system were those with high rates of GME, blended M+C payment rates, and many M+C enrollees. Because there was not complete overlap between these two sets of counties, there were counties that had hospitals that gained GME payments but did not have plans that lost M+C payments.

In other words, they had their cake and ate it too. Examples of these areas include Philadelphia, Pittsburgh, Manhattan, and Houston.

DR. ROWE: I'm a little confused by the use of the word counties because this slide says the impact of the carve-out on teaching hospitals, but you're talking about counties. Before you were talking about counties and you meant the plans.

MR. WINTER: Right.

DR. ROWE: When you say counties here now you mean the teaching hospitals?

MR. WINTER: What I'm looking at is, at the county level what were counties that had teaching hospitals that received medical education payments under the system, and also within the same county what was the impact on M+C plans payments in those counties.

DR. ROWE: I'm just suggesting in the text or whatever that we talk about teaching hospitals in counties, or health plans in counties.

DR. NEWHOUSE: Place of service versus place of residence.

DR. ROWE: Right.

MR. WINTER: I'll do that. Thank you.

Given this background on the M+C payment system and the carve-out, the Commission may wish to consider how to treat medical education payments in the context of its recommendation that payments to M+C plans and fee-for-service spending be financial neutral in local areas.

On the one hand, in its previous reports the Commission has

treated medical education payments as payments for enhanced patient care received in teaching hospitals. Thus, when we determine M+C payments GME should be treated the same as other fee-for-service spending on patient care. Therefore, it should be included in the payment rate.

On the other hand, the carve-out helps ensure that M+C enrollees have access to teaching hospitals by providing hospitals the same GME payment for M+C and fee-for-service beneficiaries. If we start to include GME in the M+C payment rates, plans would be able to use the GME for other purposes and enrollees' access to teaching hospitals could be limited.

That's my presentation and I look forward to your comments and feedback.

DR. ROSS: I just wanted to add one reiteration to what Ariel said on that to make sure it didn't get lost in the bullets because it relates to that second point, that on the other hand, which is the premise behind the carve-out was to bypass some of the negotiations that might go on. But the practical impact under the current payment system has moved money from one county to another. That was news to me and I found that interesting.

DR. NEWHOUSE: I don't know about that. If I'm a patient in Arlington and I come in and use Georgetown Hospital -- that's not what you're talking about?

DR. ROSS: No, that's not what it is. The money is moving around because of the blend issue. I don't believe, and you guys could correct me on this -- it's not a question of somebody living in Arlington and going to Georgetown. It's a question of a carve-out happening in one county and that money showing up across the country. It's a complete anomaly in the payment system.

DR. NEWHOUSE: Why is it showing up across the country? It's just not showing up in certain counties because the blends and the floors are binding there and take precedence over the carve-out. So I don't --

MS. BURKE: Isn't it showing up in teaching hospitals?

DR. ROSS: But not necessarily -- the money that is removed from the payments to M+C plans in one county is not necessarily showing up as higher payments to teaching hospitals in that county. It is showing up as higher payments to teaching hospitals in some other county.

DR. NEWHOUSE: Because those counties are in floor and blend --

DR. ROWE: The idea was to make sure that whatever county your mother lives in, who's a Medicare beneficiary, that she would have access to the academic medical centers or to the teaching hospitals that she would go to. I thought that was the idea, right? And what you're saying is that's not --

MR. MULLER: The floor factor -- I'm lost now. Is this more the floor effect, or is it more the effect of where they go compared to where they live?

MR. WINTER: The biggest impact is the anomaly in the payment rate. That is doesn't come out of the floor or the minimum update counties. The factor of people who live in Arlington going to Georgetown Hospital and therefore Georgetown Hospital getting the additional medical education payment might be a small part of that. But the much larger impact is as a result of the way the payment system is set up.

DR. NEWHOUSE: Let me try to frame because I've got to walk out of here momentarily. I think it goes along the lines Jack started but it's which type of error you would rather live with. I look at this as, this is put in as a payment to the teaching hospitals saying, if you want access to this money you're going to have to admit Medicare beneficiaries. Only from M+C, the only way you're going to be able to do that is offer the plan a competitive rate. Your rates are higher. Here's some money that you can use to subsidize your rate and compete with non-teaching hospitals for M+C business.

MS. BURKE: Joe, having been involved in this substantively at the outset, as you were, the intention as I recall was to essentially pull out of a rate that was going to be paid to an institution a teaching cost that that particular institution was not going to incur because they didn't do teaching. That in calculating the rates we wanted to separate out if you essentially were providing benefits to a Medicare beneficiary in a teaching facility, that teaching facility should receive the money that is targeted to teaching costs.

DR. NEWHOUSE: This goes back to the notion that the higher rates are really not teaching costs from the old GME report. But let me deal with the two types of errors you have. The issue is whether you -- to what degree the plans -- let's assume for the sake of argument that there's some people in teaching hospitals that could be equally well treated in non-teaching hospitals at the moment. So there's some efficiency gains from reallocating patients toward non-teaching hospitals that plans let's assume would do even if --

MR. MULLER: Contrary to patient choice --

DR. NEWHOUSE: If they got the money, that that's what they would do. On the other hand, they might also take some people out of teaching hospitals that should be in teaching hospitals by some criterion because of the financial incentive to do that if they got the money.

So as I read this carving the money out, it's basically to take both incentives away from the plans; the incentives to move out appropriately and move out inappropriately. So that the

judgment about whether it should be carved out really turns on to what degree one thinks plans would take people out appropriately versus take people out inappropriately.

DR. ROWE: What's your opinion about the effect of your epiphany on this?

DR. NEWHOUSE: I don't think it's -- what I just said, both ways it's consistent with that. That is to say I think this is --

[Laughter.]

DR. NEWHOUSE: If you say what we're buying is we're buying a different product when you have this patient at a teaching hospital, it's a different and more costly product, and it is on balance worth it, but for some patients it's not worth it. Then the issue becomes how sensitive the plan is if it gets the money rather than the teaching hospital, in removing the people that one would say by some criterion should be removed, versus removing the people that one would say shouldn't be removed.

DR. ROWE: Is your opinion influenced by the point that Murray made about the way it was actually working out?

DR. NEWHOUSE: That really is another point. I accept Murray's point, but that seems to me to argue for, if you want to pull it out of the blended counties, you should pull it out of everything and not just the floor and the blend.

MS. NEWPORT: I'm troubled by that. This is a solution that was based on the old AAPCC payment method which it was imposed simultaneous with the new payments, and we have to understand that. So the value may -- if the payment methodology had stayed the same, may have been a value. Now it's anachronistic in terms of what it does, and in effect with the 2 percent updates for most of the counties because the blend or everything else is eaten up -- eats up any rate increases, this is a zero sum game.

MR. MULLER: But the 2 percent cap would have the problems you say it has independent of this carve-out.

MS. NEWPORT: Yes. But the findings here, which may have been surprising to some people, aren't really that surprising when you look at the congruence of events and what the timing was, in terms of what it was designed to do.

MR. HACKBARTH: We've got to get this to a conclusion. On this particular topic, is there anything else that you need from us today? If not, I'll let Ray have the last word on this and then we need to go on.

DR. HARRISON: I think there are two problems. One is the short-term problem where we have money coming out of different counties and where it's going back in. And then the long-term problem is how do you rationalize this with the epiphany?

MR. HACKBARTH: We're not going to resolve those today, I dare say.

DR. STOWERS: My quick comment is two things. One, I don't think the county has anything to do with the service area, which we've said is not a major part.

My second part is this is dollars that would have been in Medicare that are now going to the Medicare+Choice plans and nowhere in fee-for-service do we try to connect where the GME dollars are coming from to where they're going, because the entire nation -- and all of Medicare pays for GME wherever it occurs. And now we're starting to try to take a local area and apply to where the GME is going.

I think we're making a quantum leap there at all to even think that the GME dollars out of a particular area that has managed care should only go to GME in that area. Because nowhere else in Medicare do we do that. The entire nation pays for GME.

So to try and link that back to one particular county --

MS. BURKE: But in the fee-for-service model it pays for --

DR. STOWERS: But as many as would have been in -- if the money, as a pool, was all paying for GME across the nation, that part was not taken out when the money was handed to Medicare+Choice.

MS. BURKE: But in fee-for-service it tracks where the person is. The multiple is applied to where the patient is as an inpatient. It's not generic. If I'm in a non-teaching hospital, I don't get an adjustment.

MS. NEWPORT: But it doesn't go to the plans.

DR. STOWERS: But in the 95 percent was the GME dollars. That's why they're taking it back. But we're trying to take it back to a specific region of the country, not taking back and putting it in the whole pool.

MR. HACKBARTH: We need to move on because we're not going to resolve this issue today.

We've got one last piece. I appreciate people's patience. It is important, though, that we at least have a preliminary look at the competitive issue. Scott?

DR. HARRISON: Another issue you won't resolve today, I'm sure.

MR. HACKBARTH: I think that's important to keep in mind, Scott. What I think we're trying to accomplish here is get the issue on the table and introduce it. Please handle your presentation accordingly.

DR. HARRISON: Let's take a look at what we might mean by the term competitive bidding, just quickly. A common conception of competitive bidding is that of a winner-take-all auction where the lowest bid wins and gets the contract. Often under these types of arrangements quality or other factors like product differentiation only make a difference if the bidding mechanism makes a provision for them.

But I want to get away from this definition because it really wouldn't do anything -- this conception doesn't do anything to add choice for beneficiaries and this really is not the premise behind any Medicare+Choice or Medicare reform proposals.

Instead, I want to focus on the conception of competitive bidding that is embodied in the concept of the free market for health insurance. Insurers would develop products with quality and other characteristics that they would include as part of their offerings or bids. Buyers, in this case beneficiaries, would face marginal price decisions for the different offerings and would make price/quality/convenience tradeoffs.

This competitive bidding concept could accommodate either using the bidding results to set the government contribution or not.

We already have this form of competitive bidding in the Medicare+Choice program. Plans compete against one another on the basis of benefits and premiums. They even compete against the Medicare fee-for-service program, although there are limits to the parameters of competition.

One of these limits will be loosened in 2003 when a BIPA provision kicks in that will allow plans to rebate all or a portion of the Part B premium to their enrollees. Currently, Medicare+Choice organizations cannot offer plans that are less expensive than the fee-for-service program, only plans with richer benefits. So this change in 2003 may change the competitive dynamics and allow freer competition with the fee-for-service program.

Even with freer competition, most beneficiaries will remain unaffected. The beneficiaries in the traditional Medicare fee-for-service program receive the same benefits at the same price, regardless of whether there are competing plans in their areas, and there are no competing plans in many areas.

Finally, an important point for this topic is that the competition does not affect the government contribution, otherwise known here as the Medicare+Choice payment rate.

Given that we have a level of competition, and in light of our recommendations for financial neutrality between enrollment in Medicare+Choice plans and enrollment in the traditional fee-for-service program, what could we hope to gain from having the results of competitive bidding being used to set the Medicare+Choice payment rates? Proponents suggest that competitive bidding would encourage greater competition, reduce Medicare costs and be more equitable across the country.

Would payment rates based on competitive bidding encourage more plan entry? In areas where there are not currently any plans, it's hard to come up with any reasons why a plan that was

not already participating would decide to participate under competitive bidding rules that could only lower payment rates compared with the financial neutrality model.

Participation could even be discouraged if competitive bidding did not include a traditional Medicare fee-for-service program. Under such a model, the plans would only be competing with themselves and low bids would result in lower payment rates and would leave the fee-for-service program unaffected. I think we saw some fears of this in the demonstrations. Because plans would be at a disadvantage relative to fee-for-service, they would be less willing to participate than under a financial neutrality framework.

One type of competitive bidding model should not hurt plan participation relative to a straight financial neutrality model and participation might perhaps increase due to a possible change in the competitive dynamics.

If the traditional program local area costs were treated as a bid, the relative bids of the plans would look the same as under financial neutrality and thus, participation would be likely to stay the same barring new dynamics.

As far as saving money, any time bids come in below the Medicare fee-for-service costs, there is the potential to lower total Medicare costs through higher premiums paid by beneficiaries.

One model would change the effects from geographic variation in fee-for-service spending. The model would result in beneficiaries in different areas paying different premiums for the traditional program instead of the current situation where different beneficiaries in different areas have access to different benefit packages at the same price.

Let's take a look at this type of model as an illustration. This model would have plans bid on a set of standard benefits. The local Medicare fee-for-service costs would be considered as the bid for the traditional Medicare plan. The payment rates would be set based on the bids. The general idea is that the rate would be set at the lowest bid and you might need to make some adjustments so that you could guarantee everybody a plan if they wanted one at the lowest bid.

Because everyone could always get into traditional Medicare, the payment rate would never be above the fee-for-service rate. In areas where there were no plans, the payment rate would always equal the fee-for-service rate. Beneficiaries would then pay additional premiums to join plans, including the fee-for-service plan, that had bids above their local payment rate. The additional premiums raised could be used either to increase the level of benefits in the nationwide standard benefit package, or could lower the overall cost of the Medicare program to

taxpayers.

What might be expected to happen under this type of system? First, the nature of the Medicare entitlement would change. Beneficiaries would no longer be entitled to receive the traditional Medicare fee-for-service program for a set premium. Instead, beneficiaries would be entitled to receive the same benefit package that is offered under the traditional Medicare program but would not be guaranteed that those benefits would be delivered through the broad choice of providers that are available in the fee-for-service program.

The gains from lower bids generated by competition would shift from the enrollees in the less costly plans -- that's currently who receives the benefits -- to all beneficiaries and/or taxpayers. All beneficiaries nationwide would have access to the basic benefit package at the same premium, but all would have to pay more if they wanted a more costly plan, unlike the current situation where beneficiaries in some areas have access to plans with extra benefits for no additional premiums.

Cost growth under this type of system would depend on the results of the annual bidding process, but total spending in any local area would be limited to the level of per capita fee-for-service spending in the traditional Medicare fee-for-service program.

That ends the presentation and I'd like to know what parts of this you'd like to see incorporated in further work, as well as any of the other topics.

MR. HACKBARTH: If I understand this correctly, this has major dramatic implications. It basically says the one competitive bidding model that makes sense from a conceptual standpoint, you basically have to abandon the entitlement to a free choice fee-for-service plan. The entitlement is no longer that. The entitlement becomes payment for the low cost bidder, which may not be a fee-for-service plan at all but a restricted choice plan. So that's a huge philosophical shift.

If you're not prepared to do that, the other models of competitive bidding don't seem to make a whole lot of sense to me, or difference. In fact, they could make things worse in terms of participation, but they're unlikely to make things better.

DR. HARRISON: I agree.

DR. REISCHAUER: What are you saying, that if you aren't willing to sign on to something like this, it's not worth pursuing? I mean, because this is really the most radical of the alternatives that are out there, and none of the legislation that's ever been proposed goes this far. The furthest would be the Bipartisan Commission where you had a weighted average reference premium, as opposed to the lowest premium.

DR. HARRISON: You could incorporate something like that, but you'd have similar results, probably.

MR. HACKBARTH: But the basic point is that you'd have to change the notion of the entitlement. It's no longer to an open choice fee-for-service plan, but rather to a bid. And that could be an average of bids, it could be the lowest bids, but it wouldn't necessarily -- or perhaps even likely -- be a free choice plan.

And so you would be paying more for --

DR. REISCHAUER: There's a question between the entitlement and what you have to pay for it and whether everybody in the nation has the right to pay the same amount. Those are sort of different variants. But there still would be an entitlement at some price to a fee-for-service Medicare benefit package.

MR. HACKBARTH: At some price.

DR. REISCHAUER: The question is, depending on where you set the reference premium, are you -- you can set it, as the President did and Breaux-Frist II does, at the fee-for-service cost in every area.

DR. HARRISON: Which is basically the financial neutrality principle.

DR. REISCHAUER: Yes, the financial neutrality principle or somewhere else.

MS. NEWPORT: I guess in our direction to you, we asked you to look at some of this stuff. I guess following on that discussion is where do we go from here, in terms of the chapter? In my mind, I think I was really thinking about are we going to set some bounds on what this could look like? What the positive/negative impacts of that might be? I guess I'm trying to figure out how we give him meaningful direction on what we really need to look at.

I think this actually was good and it helped get me to think about this a little more dynamically. But I'm not sure that we have time enough to give you the right kind of ideas on this.

Glenn, did you have a concept?

MR. HACKBARTH: I actually think what Scott presented is very helpful. The big problem right now is that we've got too little time and too few commissioners to discuss it. So rather than having Scott go off into a lot that's new, I'll defer to Bob and he'll tell Scott to go off and do a lot that's new.

DR. REISCHAUER: It strikes me that if we were going to describe illustrative models, we really should describe three at a minimum. This, one that's based with a reference premium to some average. And so in some areas fee-for-service could cost and in some areas it wouldn't. And the one which is, to the extent anything is in political play, is in play now, which is the reference premium being fee-for-service Medicare. And then

the consequences of each of those for cost savings, for enrollment, for whatever.

DR. ROSS: One of the things that would be helpful to staff -- and I recognize we need a broader participation to get this, what do we want to get out of all of these mechanisms? Part of what we wanted to bring you was the Commission has moved to this financial neutrality principle, yet everybody talks about competitive bidding. Our reaction is well, if by competitive bidding you mean plans set their own premiums, effectively we'll have that in 2003.

Then what is it we want from competitive bidding? Is it savings? Is it something else? We can bring you a couple of options and work through that.

MS. NEWPORT: You'll say that we'll have that in 2003. You're presuming we will have legislation next year to do that?

DR. HARRISON: There is a provision -- it may not be free. You will be able to come in, this year it will be $54 below the fee-for-service plan. You could rebate up to the full Part B premium next year, which you couldn't do now.

DR. REISCHAUER: With all that spare cash you have, Janet.

MS. NEWPORT: Frankly, you know, $1.40 isn't going to cut it. I'm being facetious.

I guess I'm having trouble thinking that that is a real live -- it's not on our radar screen as something that's an important competitive bidding factor.

MR. HACKBARTH: I like Bob's suggestion. We probably need to spend a little time reviewing some of the presentation from today, since a lot of people missed it, supplement it with the different models and the implications for savings and what not.

DR. HARRISON: There actually is a Health Affairs article out now. It might be only a web version. But it's by Ken Thorpe and Adam Atherly, I believe. It actually looks at three models and gives national figures for savings in enrollment. We could differ on some of the assumptions of enrollment, but I think I can cite a lot of that work.

MR. HACKBARTH: All right. We're finished with this.